SCHOOL _____

Gila County
Health & Emergency Management
Prevent. Promote. Protect.

GILA COUNTY DIVISION of HEALTH and EMERGENCY MANAGEMENT

5515 South Apache Ave., Suite 100, Globe, AZ 85501
PHONE: (928) 402-8811 FAX: (928) 425-8817

110 W. Main St. Ste. A., Payson, AZ 85541
PHONE: (928) 474-1210 FAX: (928) 474-7069

CHILD FLU ADMINISTRATION RECORD AND CONSENT

PLEASE PRINT CLEARLY

Child's **FIRST** Name Middle **LAST** Name _____

Age _____

Child's Date of Birth: Month Day Year _____

Mailing Address _____

☐ Male ☐ Female

City: _____ Zip _____

Mother's Maiden Name: _____

Telephone Number: _____

Please answer the questions below by checking "YES" or "NO" in the box on the left:

YES	NO	
☐	☐	Does your child have an allergy to eggs that causes a dangerous reaction?
☐	☐	Is your child ill and have a fever today?
☐	☐	Has your child had a serious reaction to a previous flu shot?
☐	☐	Has your child had Guillain-Barre Syndrome? (a paralytic illness)

√(check) all that apply:

☐ Uninsured ☐ Native American ☐ AHCCCS* ☐ Have Private Health Insurance*

*Primary Health Plan Name_____ Member Name _____

MEMBER ID_____ Subscriber's SSN _____

*Secondary Health Plan Name_____ Member Name _____

MEMBER ID _____Subscriber's SSN _____

ASSIGNMENT OF BENEFITS: I hereby assign to Gila County Public Health Department any insurance of other third-party benefits available for health care services provided to me. I understand that Gila County Public Health Department has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Gila County Public Health Department, I agree to forward the Gila County Public Health Department all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I agree to allow the health care provider giving vaccination to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization Information System (ASIIS), other healthcare providers and the schools in order to avoid receiving unnecessary vaccinations and to provide information in order to receive the vaccination I request.

I have read or have had explained to me the information contained in the Vaccine Information Material (08/06/2021) about the disease and the vaccine. I have the right to ask questions that will be answered to my satisfaction. I understand the benefits and risks of flu shots and authorize the Gila County Public Health Department to administer the influenza vaccine to me or the person named above for whom I am authorized to make this request. I have received a copy of my patient rights.

Parent/Guardian Signature: _____ Date:_____

Printed Parent/Guardian Signature _____ Date: _____

Child's Name_____ Date of Birth_____

VFC **INSURANCE / PAID**

INJECTION SITE

LD RD

LVL RVL

RN – Screener/Administrators Signature _____ Date: _____